ortho haus
ORTHODONTICS

Patient Referral Form

1. Referring Doctor: _____
   Referring Practice: _____
   Date: _____

2. Patient Information
   Name: _____
   Phone: _____
   Email: _____
   DOB: _____

3. Areas of Concern

☐ General Exam	☐ Deep Bite
☐ Crowding	☐ Open Bite
☐ Spacing	☐ Impacted Teeth
☐ Overjet	☐ Crossbite

Other Notes:

4. Please email referral to:

Richmond Hill Office
smile@orthohaus.com
(905) 265-4145

Collingwood Office
collingwood@orthohaus.com
(705) 444-1700

Print Form